Sexual Health Needs Assessment for Staffordshire

1. Introduction and Scope

The purpose of this needs assessment is to understand what the local needs and demands are for sexual health services to help inform the re-commissioning of the Staffordshire sexual health service, which is being carried out in collaboration with Stoke-on-Trent City Council and Telford and Wrekin Council. The document describes:

- population needs
- key sexual health data and implications on commissioning intentions
- service demand, including the impact of the coronavirus pandemic through the lens of stakeholders and service users
- key findings

The costs of delivering sexual health services is outside the scope of this assessment but will be addressed separately.

2. Population Needs

According to mid-year (2019) population estimates, Staffordshire's population is around 879,560. It is made up of a mixture of towns and villages, covered by eight district and borough council areas (Cannock Chase, East Staffordshire, Lichfield, Newcastle-under-Lyme, South Staffordshire, Stafford, Staffordshire Moorlands and Tamworth).

"Sexual health is not equally distributed within the population. Strong links exist between deprivation and sexually transmitted infections (STIs), teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM, trans community, teenagers, young adults and black and minority ethnic groups"[1].

The population characteristics of Staffordshire, including the age structure, have important implications for sexual health. According to the 2019 mid-year population estimates there are around 93,886 young people aged 15-24 and 146,913 women of child-bearing age (defined as 15-44) making up 11% and 17% of the population respectively (Table 1). A high proportion of young people live in Newcastle-under-Lyme (likely to be due to Keele University's population).

[1] Department of Health and Social care and Public Health England, Integrated Sexual Health Services-a suggested national service specification [online] available at Integrated Sexual Health Services: A suggested national service specification (publishing.service.gov.uk) [accessed 2 June 2021]

Table 1: Staffordshire Population, 2019[2]

	All Ages	Young people aged 15-24		Women aged 15-44	
		Number	Proportion of the population	Number	Proportion of the population
Cannock Chase	100,762	10,538	10.5%	18,053	17.9%
East Staffordshire	119,754	12,599	10.5%	20,269	16.9%
Lichfield	104,756	10,413	9.9%	16,612	15.9%
Newcastle-under-Lyme	129,441	17,732	13.7%	24,255	18.7%
South Staffordshire	112,436	11,446	10.2%	16,634	14.8%
Stafford	137,280	13,183	9.6%	22,335	16.3%
Staffordshire Moorlands	98,435	9,615	9.8%	14,806	15.0%
Tamworth	76,696	8,360	10.9%	13,949	18.2%
Staffordshire	879,560	93,886	10.7%	146,913	16.7%
West Midlands	5,934,037	730,119	12.3%	1,106,387	18.6%
England	56,286,961	6,578,095	11.7%	10,571,978	18.8%

Note: numbers may not add up due to rounding

Staffordshire is a largely rural area which is relatively affluent but with few notable pockets of high deprivation. Overall Staffordshire is significantly less deprived than the England average, with only 9% of its areas falling in the most deprived fifth of areas nationally. There is little ethnic diversity across Staffordshire with the population being predominantly White British. East Staffordshire has the largest proportion of people from a minority ethnic group (13.8% compared to 6.4% across Staffordshire and 20.2% for England) mainly within Burton, with the single largest minority group in this area being Pakistani[3].

ONS estimate that 2.6% of the West Midlands population are lesbian, gay or bisexual (LGB)[4] this would translate into approximately 22,868 of the Staffordshire population.

[2] 2019 mid-year population estimates, Office for National Statistics, Crown copyright

[3] Staffordshire County Council, Population demographics and adult social care needs [online] available at Population demographics and adult social care needs (all adults) - Staffordshire County Council [accessed 2 June, 2021]

[4] Office for National Statistics, Sexual Orientation, UK:2019 [online] available at Sexual orientation, UK - Office for National Statistics (ons.gov.uk) [accessed 2 June, 2021]

3. Key Sexual Health Data

There are four main public health measures, outlined in the Public Health Outcomes Framework 2019-2022, which the sexual health service, commissioned by the Local Authority (LA), support delivery against:

- Prescribing of long-acting reversible contraception (C01)
- Under 18 conceptions (C02)
- New STI Diagnoses (D02)
- People presenting with HIV at a late stage of infection (D07)

The Sexual and Reproductive Health Profiles[5] have been developed by Public Health England (PHE) to support LAs to monitor the sexual and reproductive health of the population and performance of local public related systems. The profiles are publicly available and presented as interactive maps, charts and tables that provide a snapshot and trends across a range of topics, the tools enable comparisons with other authorities and 'statistical neighbours'. In addition, Public Health England publish an annual summary profile of LA sexual health information and data[6] that provides useful statistics on sexually transmitted infections (STIs), HIV, teenage conceptions, abortions and contraception across Staffordshire. Table 2 below provides a summary of the key data for sexual health, context, and notes for commissioning intentions.

Table 2: Summary of Key Data and Context

Sexual Health Information	Data	Context	Notes for commissioning intentions:
HIV			
HIV prevalence, Late Diagnosis of HIV, and HIV testing	In 2019, the diagnosed prevalence of HIV per 1,000 residents aged 15-59 years was 0.9, better than 2.4 per 1,000 in England. The number of Staffordshire residents aged 15-59 years who were seen at HIV Services (the prevalence of diagnosed HIV) was 443. Since 2018, the increase in Staffordshire was 4%; in the 5 years since 2014, the increase was 27%.	Current key components of combination HIV prevention in the UK include: condom provision, pre-exposure prophylaxis (PrEP), expanded HIV testing and prompt initiation of treatment after diagnosis (treatment as prevention). One in five people living with HIV in the UK remains undiagnosed, It is estimated that	This data is positive, in terms of rates being similar to the national average, and overall rates of HIV in Staffordshire continue to be low. However, this is a long-term area of concern for Staffordshire, and routine HIV testing remains a priority for sexual health services.

[5] Public Health England, Sexual and Reproductive Health profiles [online] available at Sexual and Reproductive Health Profiles - PHE [accessed 26 January 2020]
[6] Public Health England, Summary Profile of Local Authority Sexual Health [online] available at SPLASH Staffordshire 2021-01-27 (phe.org.uk) [accessed 4 March, 2021]

Sexual Health Information	Data	Context	Notes for commissioning intentions:
	Between 2017 to 2019 the percentage of late diagnoses of HIV was 42.9%; 'similar' to the England percentage of 43.1%. This shows an improvement from 2015-17 where rates were higher than the national average. The Districts of Staffordshire Moorlands and South Staffordshire have rates higher than the England average at 50% and 57.1% respectively. For Staffordshire residents, the percentage of HIV diagnoses made at a late stage of infection for different risk groups in 2017 - 19 was as follows: • MSM - 30.8% (95% CI 14.3 to 51.8), similar to 34.1% (95% CI 32.7 to 35.5) in England; • heterosexual men – 58.3.0% (95% CI 27.2 to 84.8), similar to 58.0% (95% CI 55.5 to 60.4) in England; • heterosexual women – 50.0% (95% CI 11.8 to 88.2), similar to 48.6% (95% CI 46.3 to 50.9) in England. The percentage of Staffordshire residents recorded as receiving a HIV test as part of their routine sexual health service attendance has significantly reduced in 2019. This is largely a data issue caused by the changing service model and IT systems but places Staffordshire at 56.1%, **worse** than 64.8% for England.	the majority of transmission is from those with undiagnosed HIV[7]. Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality. It is a critical component of the PHOF, and monitoring is essential to evaluate the success of local HIV testing efforts. Diagnoses made at a late stage of infection are defined as having a CD4 cell count less than 350 cells per mm3 within three months of diagnosis. It is important to consider, when analysing the data, that numbers are small, and fluctuations do occur. It is also important to understand the context in terms of the different high-risk groups. HIV testing in sexual health services remains a significant tool in identifying HIV early, increasing treatment potential and reducing further transmission.	Funding for pre-exposure prophylaxis (PrEP) is now included in Public Health grant allocation. Core sexual health service will continue to be funded to ensure those most at risk of exposure are able to access the drug and essential sexual health services. Service audits have satisfied commissioners that the percentage of attendees offered a HIV test is significantly higher than the percentage reported. However, quality performance data on this issue is a key commissioning priority for the future.

[7] Public Health England, Making it work-A guide to whole system commissioning for sexual health, reproductive health and HIV [online] available at Making_it_work_revised_March_2015.pdf (publishing.service.gov.uk) [accessed on 2 June 2021]

Sexual Health Information	Data	Context	Notes for commissioning intentions:
Sexually Transmitted Infections			
STI Diagnosis Rates	A total of 4,485 new STIs were diagnosed in residents of Staffordshire in 2019. The diagnosis rate of STIs in Staffordshire during 2019 was 510 new STIs per 100,000 population and remains lower than the West Midlands rate of 655 per 100,000. The gonorrhoea diagnostic rate has increased from 32.3 per 100,000 in 2015 to 58.8 in 2019. This is much lower than the England average of 123.5 per 100,000. Syphilis cases at 7.0 per 100,000 (2019) are showing an upward trend, but still much lower than the national rate of 13.8 per 100,000. The chlamydia detection rate per 100,000 aged 15-24 was 1,660 in 2019 (1,558 positives out of 13,689 screened) **lower** than the 2,300 target and worse than the England average of 2,043.4. The proportion of 15-24 year olds screened in 2019 was 14.6% compared to the England average of 20.4%. PHE recommends that local areas achieve a rate of at least 2,300 per 100,000 resident 15-24 year olds, a level which is expected to produce a decrease in chlamydia prevalence.	As STIs are often asymptomatic, frequent screening of risk groups is important. Early detection and treatment can reduce important long-term consequences, such as infertility and ectopic pregnancy. The burden of STIs in England continues to be greatest in young people, gay, bisexual and other men who have sex with men (MSM) and black ethnic minorities. Of all age-groups, the highest STI diagnosis rates in England are in young people aged 15-24 years. High levels of gonorrhoea transmission are of particular concern due to the emergence of extensively drug resistant gonorrhoea (XDR-NG) in England. It should be noted that if high rates of gonorrhoea and syphilis are observed in a population, this reflects high levels of risky sexual behaviour. The PHOF includes an indicator to assess chlamydia in sexually active young adults under 25 years olds: the annual detection rate among	Be cautious when comparing data with national average as London borough's/districts can distort the average How can online offer support this indicator-does the available data provide evidence that service users are willing to order STI kits online and will this increase overall diagnosis rates? Recent trend shows that the rate of gonorrhoea and syphilis is increasing and getting worse (based on most recent 5 points). Close monitoring will be required by the provider, particular in the context of drug resistant gonorrhoea, and will be included in future data sets. Providers will also be expected to facilitate a high standard of testing, timely treatment, and effective partner notification for positive cases. Staffordshire commissioners took the decision to cease the chlamydia screening programme in the community and prioritise funding elsewhere. For this

Sexual Health Information	Data	Context	Notes for commissioning intentions:
		the resident 15-24 year old population. The detection rate reflects both coverage and the proportion testing positive at all sites, including sexual health services diagnoses as well as those made outside of sexual health services. Since chlamydia is most often asymptomatic, a high detection rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. The detection rate is not a measure of prevalence. Please note that there are changes to the focus of the National Chlamydia Screening Programme (NCSP)[8]	reason, providers will be expected to offer chlamydia screening routinely to all patients, regardless of their need.
Long Acting Reversible Contraception-interpret with caution			
LARC excluding injections rate	The total rate of long-acting reversible contraception (LARC) (excluding injections) prescribed in Staffordshire primary care, specialist and non-specialist sexual health services was 43.8 per 1,000 women aged 15-44 years in 18/2019, lower than the rate of 50.8 per 1,000 women in England.	LARC provision is likely to reflect local geography and service models e.g. there may be more provision in primary care in more rural and semi-rural areas.	The new specification will include the requirement of a Prime Provider model for LARC delivery within GP settings-this will ensure that the appropriate level of knowledge and expertise is available to fitters

[8] Changes to the National Chlamydia Screening Programme (NCSP) 24 June 2021 [online] available at Changes to the National Chlamydia Screening Programme (NCSP) - GOV.UK (www.gov.uk) [accessed on 25 June 2021]

Sexual Health Information	Data	Context	Notes for commissioning intentions:
	GP prescribed long acting reversible contraception (LARC) rates in 2019 were 30.4 per 1,000 women of reproductive age. This is similar to the national rate of 30.0 Please note the above data does not reflect what is presented on PHE fingertips. The rate prescribed within SRH Services was 13.4 in 2019, lower than the rate of 20.8 in England.		For Staffordshire, the GP prescribed LARC data on PHE fingertips does not accurately reflect local provision. This is due to the way the provision of LARCs is commissioned locally. The local model enables Staffordshire GPs to purchase the devices directly rather than use the FP10 prescription route. Due to this the data is not included within the e-PACT data which is used to inform the GP prescribed LARC data on PHE fingertips.
Teenage Conception			
Teenage Conception Rates	Nationally, teenage conceptions are on the decline. In 2018, the under-18s conception rate per 1,000 females aged 15-17 years in Staffordshire was 16.8, similar to the rate of 16.7 per 1,000 in England. Between 1998 and 2018, the decrease in the under-18s conception rate in Staffordshire was 61%, compared to a 64% decrease in England. Data on the PHOF show that rates vary across the county with Tamworth recording a rate of 28.0 per 1,000 in 2018.	Teenage pregnancy is a cause and consequence of education and health inequality for young parents and their children Measures to reduce teenage pregnancy need to be both universal and targeted. Although two-thirds of young people do not have sex before 16 years, by 20 years, 85% will have experienced vaginal intercourse, so all young people need good RSE and access to services to prevent early pregnancy and to look after their sexual health. Universal prevention programmes are also essential to	Teenage pregnancy is not just a sexual health issue and other factors, including levels of deprivation, play a role. Due to the low actual numbers, Staffordshire has seen spikes in recent years in various borough, including in Newcastle, Cannock, and most recently Tamworth. All have pockets of deprivation. Staffordshire Public Health are not commissioning sexual health services to directly tackle the causes of teenage pregnancy. However, providers will be encouraged to support local efforts

Sexual Health Information	Data	Context	Notes for commissioning intentions:
		reduce rates by a substantial margin. From September 2020, new legislation requires all primary schools to provide relationships education, all secondary schools to provide relationships and sex education and both primary and secondary schools to provide health education, including puberty.	to support young people, including networking with other local providers of services for young people. Providers will also be supported by commissioners, if they choose, to provide commercial services to promote positive sexual health to local education providers.
Abortions			
Abortion Rates	In 2019 there were 2,653 terminations of pregnancy, which is a rate of 18.1 per 1,000 women aged 15-44 years old, similar to the rate in England of 18.7 per 1,000. In Staffordshire, the percentage of NHS-funded abortions that were under 10 weeks was 79.3% in 2018, **worse** than the percentage in England of 82.5. In Staffordshire, the percentage of NHS-funded abortions that were under 10 weeks that were medical was 87.2% in 2018, higher than the percentage in England of 84.3%[9]	Abortion rates are calculated and produced by the UK Government via statutory returns. https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2019 There are a variety of providers which carry out abortions for Staffordshire area. The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is required.	Whilst abortion services fall out of the scope of the sexual health services, Commissioners will expect providers to adhere to national guidance for any woman in their care for which abortion is an option. Providers will also be expected to develop established effective pathways between sexual health services, sexual assault services, and abortion services.

[9] Summary Profile of Local Authority Sexual Health [online] available at SPLASH Staffordshire 2021-01-27 (phe.org.uk)

4. Understanding Demand

4.1 Configuration and model of the service prior to COVID-19

Sexual health services are universal and operate on an open access basis. For this reason, services should be made available to anyone who requires them. However, particular focus should be given to ensure that those vulnerable to poor sexual health, or have limited access to other forms of support, can access services easily and when they require them. These groups include under 25-year olds; men who have sex with men; people with chaotic lifestyles including those known to addiction services, and sex workers.

Prior to COVID-19 Staffordshire services were delivered as follows:

- Level 3 GUM clinics located in Cobridge (shared clinic with Stoke-on-Trent), Stafford, Tamworth, and Burton
- Two contraception and sexual health clinics (CaSH) clinics in Newcastle-under-Lyme and Cannock (closed for much of 2020/21 as a result of Covid-19)
- No clinics are available in the districts of Staffordshire Moorlands and South Staffordshire
- Online testing and treatments are also available through this service model

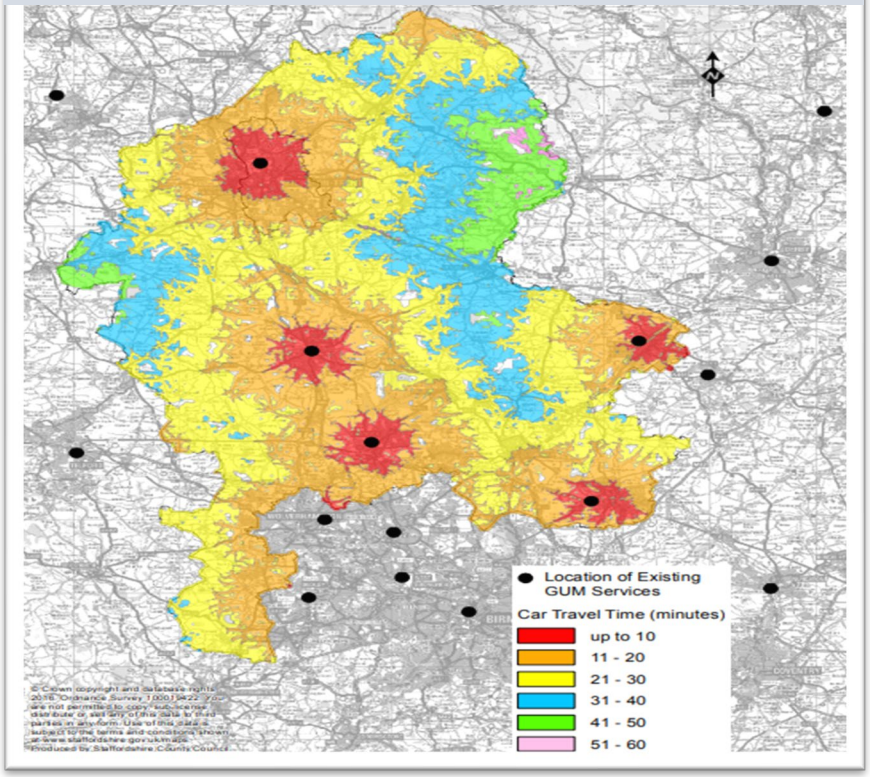
In addition:

- Pharmacy led provision of Emergency Hormonal Contraception (EHC) commissioned through a Prime Provider Model and delivered in 78 Staffordshire pharmacies (financial year 2021/22).
- GPs providing Long Acting Reversible Contraception to their patients as part of enabling choice alongside other methods of contraception. 67 Staffordshire GP surgeries participate (financial year 2021/22).

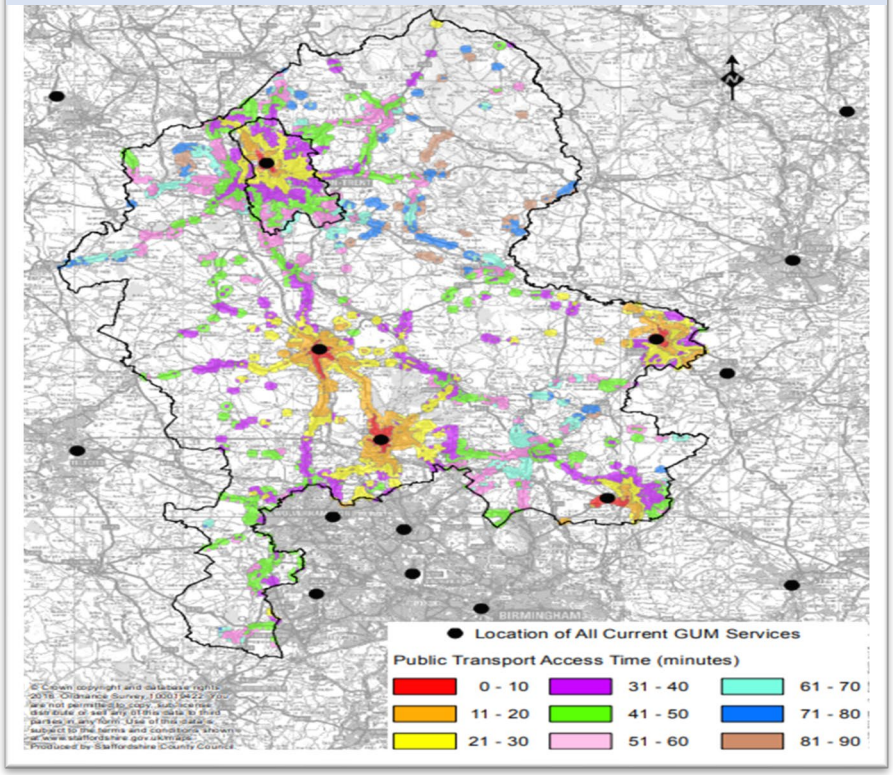
4.2 Access to Services

Travelling distances to clinics, via car and public transport, can be mapped for the successful provider to support planning and understanding of accessibility to clinic locations.

Map 1 displays car travel time to the GUM services that were operational at the time and shows that service users were able to travel to a clinic within a maximum of 60 minutes.



Map 2 displays public transport access times to the GUM services, that were operational at the time, and shows that service users were able to travel to a clinic within a maximum of 90 minutes.



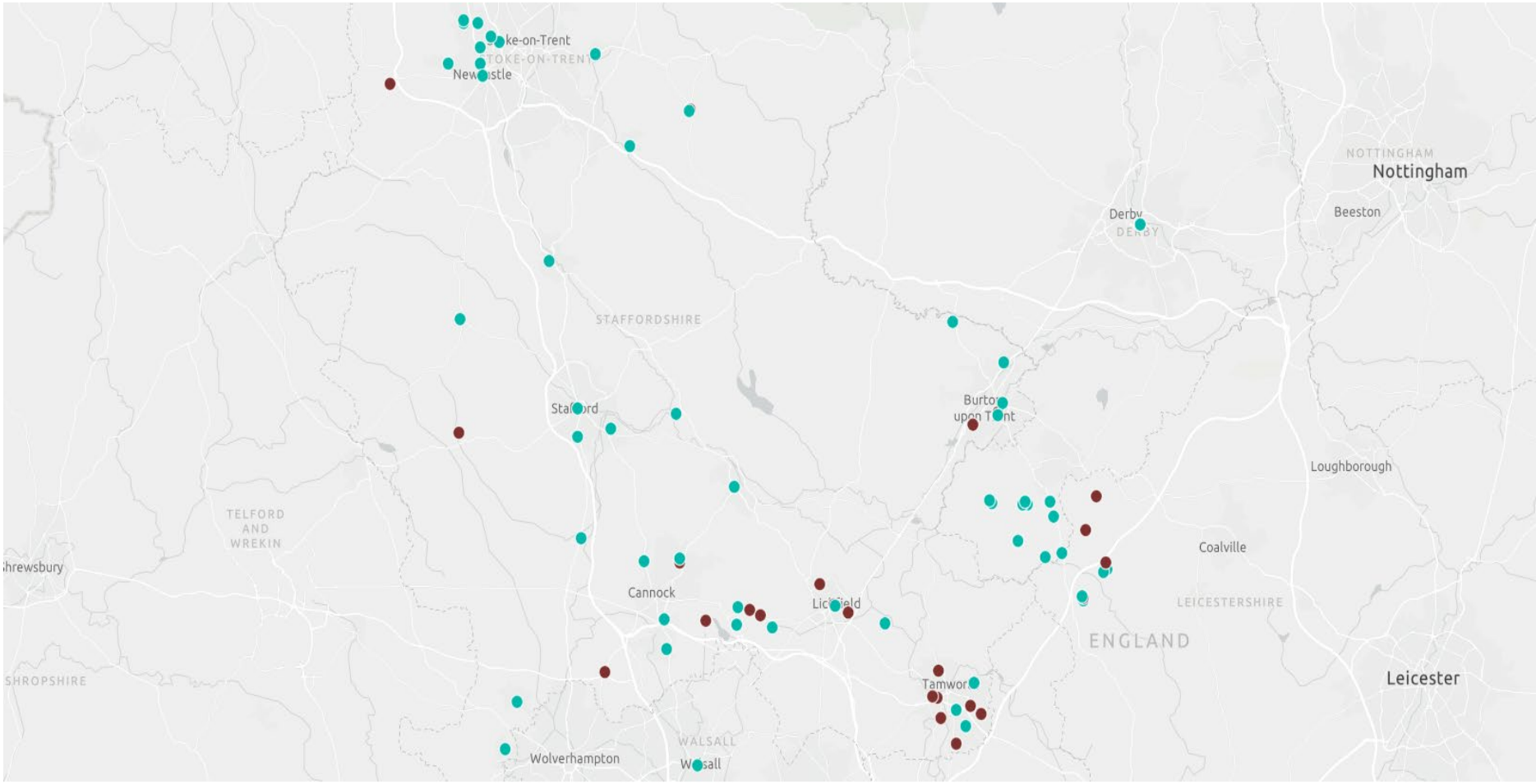
4.3 Effectiveness of Current Model

4.3.1 Summary of results from provider engagement

Key providers of the services include the Midlands Partnership NHS Foundation Trust (MPFT), Lloyds pharmacy which are the prime provider for delivery of EHC across community pharmacists, and GP surgeries who are contracted individually to deliver a LARCs service. These providers were asked to describe the elements of the service which, prior to COVID, worked effectively and the challenges they faced:

- Walk in and booked appointments to the sexual health service, delivered by MPFT, worked well however demand was high and managing patient flow to decrease waiting lists was required. In the South a fast pass system was developed to help ease the waiting list for walk ins, although this is not currently in place due to the removal of walk ins as a result of COVID
- C-Card distribution points enabled access for all residents, regardless of where they live.
- Educational establishment such as Keele University and Newcastle-under-Lyme College used to pay MPFT for outreach work but this hasn't been in place for a couple of years
- The sexual health service sits within the Inclusion team which enables useful links to be established with other key services such as drugs and alcohol and psychological therapy and wellbeing as well as prisons.
- GP LARC provision is accessible and convenient for patients who prefer to access the service through their GP surgery. However, there is a lack of training opportunities and communication between the core service needs to be improved.
- EHC provision is delivered by community pharmacists and managed by Lloyds as the Prime Provider. Although not all community pharmacists deliver the service, even after completion of the required training, those that do deliver a good quality service. It was felt that there is more that pharmacists can do in terms of contraception and STI screening.
- The map below shows the **active** and **inactive** pharmacies across Staffordshire (based on pharmacy activity 2020/21)

Map 2: Active and Inactive Pharmacies delivering Emergency Hormonal Contraception (2020/21)



4.3.2 Summary of results from public consultation

A consultation exercise explored the experiences, needs and preferences of service users who have accessed sexual health services across Staffordshire, Stoke-on-Trent and Telford and Wrekin. This was developed collaboratively due to the planned joint commissioning of the service.

Demographics:

- The majority of respondents (33%) were age 25-34 with 27% coming from the 35-44-year-old category and 20% from the 45-64 year old age group, only 12% and 5% were from the 18-24 and 16-17 year old age groups respectively.
- 68% of respondents were female, 24% were males with 5% preferring not to say, 1% preferring to self-describe and 1% not answering.
- 74% of respondents selected heterosexual (straight) with 15% of respondents selecting gay, 6% 'preferred not to say' and 5% selected bisexual.
- 88% of respondents selected White-English/Welsh/Scottish/Northern Irish/British, with 4% selecting any other White background, 3% selecting Black/African /Caribbean/Black British, a further 3% selecting Mixed/multiple ethnic group and 1 respondent 'preferred not to say'.

Due to the limited demographics of the respondents the results should be interpreted with caution.

The results of the survey showed that:

- 65% of respondents currently use the Sexual Health Service for information and advice on sexual health, with website being the next highest at 44% followed by Doctor/GP/Practice Nurse at 38%
- When asked whether there is anything that can be done to improve the experience of the service attended responses could be themed into the following two areas:
    - Accessibility and choice of service. For example, one service user from Cannock stated that they *"use my GP surgery as local service in Cannock is closed. My nearest sexual health clinic is Stafford which is a long bus journey away and I'd like one closer to home".* Another service user from Stafford wants "*better hours around work*" as "*I used to attend the GUM clinic for my contraceptive injection as it was convenient with evening hours to attend outside of work. I now have to go via my GP who don't offer an out of hours service so I have to request time off work".* A Stafford resident requested that booked appointments continue to *"save long waiting in clinic".*
    - Confidence in staff and or information provided. A small number of respondents were not satisfied with the information provided. For example, one service user from Burntwood suggested that "*the online service and the clinics ie Branston and Stafford, need*

to meet and make sure they are all giving people the same advice as at the moment they are NOT. Very confusing! And a service user from Stafford stated *"Give advice on incubation periods of certain bacterial disease to stop false negative results and to make ppl more aware".* One respondent from Stafford informed us that the "receptionist was rude because I wear a badge to state I can't wear a face mask and she tried making me wear one"

There were also positive comments about how helpful and supportive staff are. For example, one service user from Tamworth said that "*nothing should change…brilliant service and wonderful staff*" with another from Lichfield saying that staff were "*helpful and supportive".*

- 80% of respondents felt that the service they currently go to for information and advice on sexual health meets their needs. For those that didn't think it meets their needs one respondent thought that it was "*too far to travel without own transport"*.
- When asked where they would most like to get information and advice on sexual health from 80% stated the Sexual Health Service/clinic, followed by 47% Doctor/GP/Practice Nurse with 37% indicating a website. 'Other' included *"pop up clinic to give more people the opportunity to be treated and tested"*

4.4 Impact of Covid-19 on Staffordshire's Service Provision

During lockdown sexual health clinics were closed to all but urgent need. Symptomatic and non-symptomatic patients were redirected online and non-essential procedures were cancelled. In addition, routine procedures, including new, and long acting reversible contraception (LARCs), were cancelled. GP practices also stopped their provision of LARCs in line with BASHH guidance. Initially, this had minimal impact as sexual activity was also greatly reduced at this point in the year.

The impact of the first lockdown resulted in a growing waiting list for LARCs (contraceptive coils and implant fitting and removals) of over 1000 women. The number of GPs who began fitting LARCs again was small and there was a 71% decrease in the number of GP fitted LARCs between April and September 2020 compared with the same period in the previous year (1393 fewer fittings in GP practices). There was also a 75% decrease (444 fewer) in the number of women having their LARCs removed. Discussions took place with the CCG and primary care and a plan was developed to increase the number of GP LARCs fitters re-commencing fittings to reduce this waiting list in the core services.

MPFT set out a restoration plan which outlines how the service will restore in line with the Government roadmap, adapting it to any local or national changes as required.

The results of the engagement work with key service providers, potential bidders and service users describe the impact of COVID-19 on services and what this means for future provision.

4.4.1 Summary of results from engagement with stakeholders

Stakeholders were engaged via several methods including surveys, Teams meetings and a networking event. The key findings of this engagement work is described below:

- Overall, participants were positive about continuing to deliver a hybrid model which offers a range of on-line, telephone and face to face contact.
- Retain 'walk ins' for those who are vulnerable.
- Safeguarding our vulnerable service users is critical
- Continuing restrictions and on-going infection control affect the number of service users able to access appointments both for the sexual health service and those delivered in primary care.
- Accessibility for young people is critical
- There is a need to continue opportunistic interventions such as cervical screening and HPV immunisation
- Consider the impact the change has had in footfall on out of area service users. What impact will this then have on shifting of funding which is currently significant for out of area
- Staff training worked well online, especially for school staff
- There is a need to join within the wider health care settings to meet the needs and understand the wider impact of COVID on people.
- Establish relationships with Primary Care Networks (PCNs)
- Use non-registered healthcare professions to provide condoms and self-testing clinics
- Use service and outcome data to inform and develop the service
- Use nurses to deliver LARC as they are willing to be trained but need to consider how the training is funded

4.4.2 Summary of results from market engagement

A market engagement questionnaire was made available on the procurement portal and interested bidders were invited to provide insight to shape the service specification:

- Interested bidders were asked how commissioners can ensure that the specification reflects the need for an equitable service model whilst also ensuring those at a higher risk of poor sexual health are reached in a way that meets providers' capacity and capabilities. Key points included:
    - outreach/face to face clinics for those most in need and at risk
    - remote/online clinics and self-help was felt important to allow resources to be made available for the above
    - clear KPIs to support the above points
    - importance of partnership working in terms of understanding what other partners are delivering

- Interested bidders were asked how commissioners can ensure that the specification responds to the uncertainty that COVID-19 has created regarding demand for sexual health services and the way that patients will interact with them in the future, key points included:
    - the majority of responses requested flexibility within the contract with a need to include digital/virtual provision as well as face to face
    - working collaboratively was felt to be important to interested bidders
    - ensuring contingency plans are requested as part of the bidding process was requested
    - it was suggested that an innovation element is included within the specification

4.4.3 Summary of results from public consultation

Respondents were asked a number of questions about future needs of the service, the questions and responses are described below:

- Of the respondents who answered the question 'where they would prefer to access the contraceptive pill or emergency contraception from in the future' 27% stated the Sexual Health Service/clinic, 18% stated Doctor/GP/Nurse with 16% stating 'any of the above'.
- When asked where they would go for information and advice if they were concerned about having a sexually transmitted infection or HIV and wanted to be tested 59% stated the Sexual Health Service/clinic.
- Respondents were asked what the most important factors are when accessing face to face Sexual Health Services/clinics in the future. Responses were as follows, note respondents could select multiple options:

Option	Percent
Service is confidential	62.1%
Staff are non-judgemental	60.6%
Staff put me at ease	54.6%
Open at the weekend	50.0%
Variety of ways to book an appointment (telephone, text, online, in person)	50.0%
Open during the day	45.5%
Open before or after school, college or work	45.5%
Appointment system	45.5%
Close to home	40.9%
Respect my sexuality	24.2%
Choice of seeing male/female medical staff	24.2%
Choice of whether another person can attend my appointment with me for support	18.2%
Walk in and wait	16.7%

Easy to reach by public transport	13.6%
Respect my cultural/religious beliefs	9.1%
No answered	3.0%
Other	1.5%

- Respondents were asked what the most important factors are when accessing online Sexual Health Services/clinics. Responses were as follows, note respondents could select multiple options:

Option	Percent
Accurate and easy to understand information, advice and guidance on a range of sexual health issues	62.1%
Confidentiality	62.1%
Clear information on what services can and can't be offered online	56.1%
Clear and up to date information on where local clinics are and how these can be accessed	53.0%
Ability to ask questions to a qualified health professional	47.0%
Ability to test, diagnose and treat Sexually Transmitted Infections (STI's) without the need to access a face to face clinic (where appropriate)	43.9%
Accessible via a variety of web browsers (e.g. Safari, Firefox, Edge and Chrome)	33.3%
Easy to navigate	33.3%
Information on how to maintain a healthy lifestyle to support good sexual health	27.3%
Safety	21.2%
Ability to assess what different contraceptive methods are suitable for me	21.2%
Information on other related support services for example sexual assault, mental health support, alcohol and drugs	21.2%
Appropriate for sexuality	18.2%
Appropriate for cultural/religious beliefs	4.6%
Not answered	3.0%
Other	0.0%

- When asked which of the following, if any, would they consider ordering online if they were delivered in a plain, letterbox friendly package STI testing kits came out the highest at 68%

Option	Percent
STI Testing kits	68.2%
Treatment for certain STIs such as genital warts	57.6%
Emergency Contraceptive Pill	39.4%
None of the above	4.6%
I prefer not to say	3.0%
Not answered	3.0%

- When asked where they would want to receive an STI test in the future, if they were looking to order a free testing kit from the internet, the majority 80% stated 'to my home address'. Other suggestions included they are sent to a different address or have the ability to order an additional address e.g friend or work
- If requiring an STI test in the future 78% of respondents would prefer to receive the results via text. Although a phone call from a health professional or face to face appointment was also acceptable for 40% and 32% of respondents respectively. Please note respondents could select all that apply.
- When asked what might put them off using a face to face sexual health clinics in the future the following responses were given:
    - Waiting for a long time for example *"When the service is only walk in as **you could end up waiting a significant time** for something quick" (Stafford)*
    - Location for example *"If not local to me **I don't want to have to travel**" (Cannock)*
- When asked what might put them off using an online sexual health clinic in the future the following responses were given:
    - Face to face is valued, for example *"Would use if desperate but would **prefer the face to face option**" (Stafford) "**prefer face to face contact** with a nurse or doctor in clinic" (Tamworth) "**prefer** face to face consultation" (Tamworth) "**prefer** face to face" (Tamworth)*
    - Security, for example *"the **safety** of my clinical information" (Stoke-on-Trent) "**hackers**" (Stone)*
    - Accuracy of information *"information **not accurate and specific** to me" (Stafford)*
- When asked whether they had any further comments on how sexual health services can be made more accessible to local people the following responses were given: (basically, more clinics and less waiting time)
    - Increase clinics/staff, for example *"I believe there should be **more clinics** available at local community hospitals to make it accessible to all-in the last few years the local clinics have disappeared, and a lot of patients don't have the availability to transport" (Lichfield)"have **more local clinics** available" (Cannock) "**more clinics and less waiting times**" (Stafford) "By maintaining the service in the area that is accessible to the local community, especially young people who rely on public transport. **Increase the number of days** the clinic is open in the local area" (Tamworth) "**longer opening hours** at our local clinic" (Tamworth)*

- Prevention, for example *"open up the offering of **PreP** on NHS to more people more quickly" (Telford)*

5. Key Findings

5.1 Summary of the key findings of the consultation exercises:

1. The development and delivery of effective online, telephone and other remote offers which:
    a. support the popularity and effectiveness of online and other remotely delivered services whilst protecting resources for those most at risk
    b. support the need to significantly reduce the availability of universal 'walk-in' services, which have become unmanageable.
    c. meet FRSH standards[10] (Safe, Effective, Treats people with Kindness, Respect and Compassion, Responsive, Governance and Leadership)
    d. support effective safeguarding (designated safeguarding lead, ensures policies are available for all staff, completion of relevant safeguarding training, procedures in place for escalation of safeguarding issues)
    e. adhere to data protection laws
    f. are supported by data managements systems which help with the collection and reporting of key data against relevant outcomes
    g. have a robust system in place to ensure user and public involvement is encouraged and developed
    h. reflect the continual growth of evidence and research
2. Delivery of face to face consultations in areas of greatest need and for groups vulnerable to poor sexual health, to address:
    a. the higher needs in certain districts such as Tamworth which have high rates of teenage pregnancy and low rates of Chlamydia testing and Staffordshire Moorlands which has high rates of late diagnosis of HIV and low rates of Chlamydia testing as well as being rural
    b. the balance of delivering universal online services whilst ensuring the needs of particular vulnerable groups, for example young people and sex workers or those living in rural areas, are met
    c. concern that some vulnerable groups cannot easily utilise the full range of online services e.g testing kits delivered to home address
    d. data protection and GDPR laws which expect services to demonstrate that individuals aged under 16 have capacity to consent to their data being collected and processed remotely-as this is difficult to demonstrate legal through online services FSRH recommend that individuals, aged 16 and under, are signposted to face to face services
3. Identify opportunities, within the system, to strengthen business continuity options in the event of unplanned clinic closures such as:

[10] FSRH/BASHH Standards for Online and Remote Providers of Sexual and Reproductive Health Services - January 2019 - Faculty of Sexual and Reproductive Healthcare

    a. look at options for Primary Care Networks (PCNs) to support delivery of LARCs within their area
    b. understand range and costs of online sexual health services, that will not routinely be offered, to ‘call on’ if required
    c. provide flexibility within the contract to enable the provider to be responsive to change
4. Interdependencies
    a. services need to be commissioned in a joined-up way to enable pathways to flow between related services
    b. prevent duplication and fragmentation between sexual health services and other sexual health and reproductive services
    c. the impact of de-commissioning of inter-dependant services on pathways and services needs to be considered

Other general issues that have arisen during the data analysis, engagement work and/or other discussions that are not limited to the impact of COVID but need to be considered include:

5. Effective delivery of Making Every Contact Counts within the sexual health service which:
    a. makes use of the opportunities during consultations to deliver MECC to support a rage of health and wellbeing e.g mental health
    b. ensures staff are equipped with the skills and knowledge to deliver MECC interventions
    c. is supported by data management systems which collect and report on relevant key data
    d. is underpinned by a clear evaluation framework to understand effectiveness
6. Development of robust data management systems which support data quality and the accurate collection and reporting of data. Areas to strengthen include:
    a. capturing of waiting times of LARCs patients to analyse how long women are waiting
    b. development of mandated fields (as part of mobilisation period) to ensure data is being recorded in relation to the outcome late diagnosis of HIV
    c. increased validation checks to support data quality

5.2 Overarching summary of findings for Staffordshire, Stoke-on-Trent and Telford & Wrekin

As the service is to be jointly commissioned the needs assessment concludes with an overarching summary of all the consultation work that has been implemented across the three areas. This will be taken forward into the joint specification:

1. Online access to STI testing and treatment should be available for all, reserving face to face services for those most at need
    a. Protecting resources for the most at risk
    b. Complex cases can get appointments easily
    c. The risks of missing people in need should be carefully mitigated through safeguarding procedures
2. Patient Centred Care
    a. Shorter waiting times
    b. Confidentiality and privacy for the patient
    c. Person choice and preference should be respected
    d. Patients should be able to access the right service or see the right person, at the right time, in the right place for them
    e. Outreach should be targeted at those most at risk of poor sexual health
3. Greater emphasis on working in partnership to ensure there are clear pathways between services
    a. No wrong door
    b. All providers are clear on who is commissioned to provide what
    c. Every contact counts for safeguarding and sexual health messages
4. Progress and Innovation
    a. Learn from the experience of Covid-19
    b. Don’t over-specify

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